		FOR OHF USE					

LL1

2005
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2005)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0021238

Facility Name: P.A. Peterson Center for Health

Address: 1311 Parkview Avenue (Number) Rockford (City) 61107 (Zip Code)

County: Winnebago

Telephone Number: (815) 399 - 8832 **Fax #** (815) 399 - 8342

IDPA ID Number: 36-2584799 - 004

Date of Initial License for Current Owners: 1941

Type of Ownership:

X	VOLUNTARY,NON-PROFIT		PROPRIETARY		GOVERNMENTAL		
	X	Charitable Corp.		Individual		State	
		Trust		Partnership		County	
IRS Exemption Code	501 (C) (3)			Corporation		Other	
				"Sub-S" Corp.			
				Limited Liability Co.			
				Trust			
				Other			

In the event there are further questions about this report, please contact:
Name: Sonia Channa **Telephone Number:** (847) 390 - 1411

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 07/01/2004 to 06/30/2005 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) _____ (Date)
(Type or Print Name) Frederick Aigner
(Title) President

Paid Preparer
(Signed) _____ (Date)
(Print Name and Title)
(Firm Name & Address)
(Telephone) ( ) Fax # ( )

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

Facility Name & ID Number P.A. Peterson Center for Health # 0021238 Report Period Beginning: 07/01/2004 Ending: 06/30/2005

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds 173 Date of change 08/15/02

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	122	Skilled (SNF)	122	44,530	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5	51	Sheltered Care (SC)	51	18,615	5
6		ICF/DD 16 or Less			6
7	173	TOTALS	173	63,145	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF			8,762	8,762	8
9	SNF/PED					9
10	ICF	9,490	17,893		27,383	10
11	ICF/DD					11
12	SC		4,976		4,976	12
13	DD 16 OR LESS					13
14	TOTALS	9,490	22,869	8,762	41,121	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 65.12%

D. How many bed-hold days during this year were paid by the Department?
0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
Out Patient Therapy

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [N / A]

I. On what date did you start providing long term care at this location?
Date started 1941

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date NO [X]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 28 and days of care provided 8,762

Medicare Intermediary Adminastar

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 06/30/2005 Fiscal Year: 06/30/2005

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number P.A. Peterson Center for Health # 0021238 **Report Period Beginning:** 07/01/2004 **Ending:** 06/30/2005

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	364,217	25,362	33,131	422,710		422,710		422,710			1
2	Food Purchase		278,843		278,843		278,843	(7,180)	271,663			2
3	Housekeeping	143,431	32,789	2,301	178,521		178,521		178,521			3
4	Laundry		2,049	145,445	147,494		147,494		147,494			4
5	Heat and Other Utilities			209,188	209,188	2,245	211,433	(13,125)	198,308			5
6	Maintenance	103,436	42,046	129,522	275,004	11,302	286,306		286,306			6
7	Other (specify):* Rubish/Medical Removal			14,076	14,076	1,470	15,546		15,546			7
8	**TOTAL General Services**	611,084	381,089	533,663	1,525,836	15,017	1,540,853	(20,305)	1,520,548			8
	B. Health Care and Programs											
9	Medical Director			24,340	24,340		24,340		24,340			9
10	Nursing and Medical Records	2,751,102	397,754	14,322	3,163,178		3,163,178		3,163,178			10
10a	Therapy			1,536,208	1,536,208		1,536,208		1,536,208			10a
11	Activities	125,366	6,930		132,296		132,296		132,296			11
12	Social Services	101,799			101,799		101,799		101,799			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	2,978,267	404,684	1,574,870	4,957,821		4,957,821		4,957,821			16
	C. General Administration											
17	Administrative	46,073			46,073	475,457	521,530		521,530			17
18	Directors Fees											18
19	Professional Services			994,500	994,500	(805,803)	188,697	265	188,962			19
20	Dues, Fees, Subscriptions & Promotions			46,703	46,703	16,779	63,482		63,482			20
21	Clerical & General Office Expenses	119,153	21,278	47,359	187,790	35,220	223,010		223,010			21
22	Employee Benefits & Payroll Taxes			997,044	997,044	110,256	1,107,300		1,107,300			22
23	Inservice Training & Education					16,708	16,708		16,708			23
24	Travel and Seminar			15,792	15,792		15,792		15,792			24
25	Other Admin. Staff Transportation					8,032	8,032		8,032			25
26	Insurance-Prop.Liab.Malpractice			294,502	294,502	23,314	317,816		317,816			26
27	Other (specify):*					93	93	(93)				27
28	**TOTAL General Administration**	165,226	21,278	2,395,900	2,582,404	(119,944)	2,462,460	172	2,462,632			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	3,754,577	807,051	4,504,433	9,066,061	(104,927)	8,961,134	(20,133)	8,941,001			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number P.A. Peterson Center for Health #0021238 Report Period Beginning: 07/01/2004 Ending: 06/30/2005

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			408,856	408,856	47,148	456,004	(557)	455,447			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			248,698	248,698	12,775	261,473		261,473			32
33	Real Estate Taxes			143,938	143,938	104	144,042		144,042			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			23,642	23,642	42,300	65,942		65,942			35
36	Other (specify):*											36
37	**TOTAL Ownership**			825,134	825,134	102,327	927,461	(557)	926,904			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			73,295	73,295	2,600	75,895		75,895			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**			73,295	73,295	2,600	75,895		75,895			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	3,754,577	807,051	5,402,862	9,964,490		9,964,490	(20,690)	9,943,800			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number P.A. Peterson Center for Health # 0021238 Report Period Beginning: 07/01/2004 Ending: 06/30/2005

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(7,180)	2		4
5	Telephone, TV & Radio in Resident Rooms	(13,125)	5		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	696	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(1,081)	9,27,30		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (20,690)		$	30

OHF USE ONLY								
48		49		50		51		52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (20,690)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule		X			45
46	Other-Attach Schedule		X			46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS

P.A. Peterson Center for Health

ID# 0021238

Report Period Beginning: 07/01/2004

Ending: 06/30/2005

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Adjust in Advertising & Promotions- Mgmt	$ 57	27	1
2	Adjust out Advertising & Promotions-Serv Network	(150)	27	2
3	Adjust in Allowable Mgmt & HR allocation	270	19	3
4	Adjust in Allowable Service Network Allocation	(5)	19	4
5	Adjust Out Management auto depreciation	(45)	30	5
6	1995 CORF Adjustment IDPA	(1,208)	30	6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(1,081)		49

STATE OF ILLINOIS — Summary A

Facility Name & ID Number P.A. Peterson Center for Health # 0021238 **Report Period Beginning:** 07/01/2004 **Ending:** 06/30/2005

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(7,180)	0	0	0	0	0	0	0	0	0	0	(7,180)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	(13,125)	0	0	0	0	0	0	0	0	0	0	(13,125)	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(20,305)	0	0	0	0	0	0	0	0	0	0	(20,305)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	265	0	0	0	0	0	0	0	0	0	0	265	19
20	Fees, Subscriptions & Promotions	0	0	0	0	0	0	0	0	0	0	0	0	20
21	Clerical & General Office Expenses	0	0	0	0	0	0	0	0	0	0	0	0	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	(93)	0	0	0	0	0	0	0	0	0	0	(93)	27
28	**TOTAL General Administration**	172	0	0	0	0	0	0	0	0	0	0	172	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(20,133)	0	0	0	0	0	0	0	0	0	0	(20,133)	29

STATE OF ILLINOIS **Summary B**

Facility Name & ID Number **P.A. Peterson Center for Health** **#** **0021238** **Report Period Beginning:** **07/01/2004** **Ending:** **06/30/2005**

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	(557)	0	0	0	0	0	0	0	0	0	0	(557)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(557)	0	0	0	0	0	0	0	0	0	0	(557)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(20,690)	0	0	0	0	0	0	0	0	0	0	(20,690)	45

Facility Name & ID Number P.A. Peterson Center for Health # 0021238 Report Period Beginning: 07/01/2004 Ending: 06/30/2005

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
N/A	N/A	N/A	N/A	Vesper Mgmt Corp	Des Plaines Illinois	Mgmt co.
				LSSI	Des Plaines Illinois	Corp. Office

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [ ] YES [X] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V		N/A	$	N/A		$	$	1
2	V								2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$			$	$ *	14

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

Facility Name & ID Number P.A. Peterson Center for Health # 0021238 Report Period Beginning: 07/01/2004 Ending: 06/30/2005

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	N/A								$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

*** If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.**

**** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION**

Facility Name & ID Number P.A. Peterson Center for Health # 0021238 Report Period Beginning: 07/01/2004 Ending: 6/30/2005

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Lutheran Social Services of Illinois
Street Address: 1001 E. Touhy Ave. Ste 50
City / State / Zip Code: Des Plaines, IL 60018
Phone Number: (847) 635-4600
Fax Number: (847) 635-6764

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	17	Salaries & Wages	Non Capital Direct Costs	31,532,610	275	$ 2,761,123	$ 2,761,123	3,677,175	$ 321,988	1
2	22	Empl Benefits & Taxes		31,532,610	275	497,832		3,677,175	58,055	2
3	19	Prof Fees & Contract		31,532,610	275	403,737		3,677,175	47,082	3
4	21	Supplies, Telephone		31,532,610	275	219,203		3,677,175	25,562	4
5		Postage, Out. Printing		31,532,610	275	0		3,677,175	0	5
6	34	Rental of Space		31,532,610	275	360,199		3,677,175	42,005	6
7	5	Utilities		31,532,610	275	19,251		3,677,175	2,245	7
8	6	Bldg Repairs & Maintenance		31,532,610	275	49		3,677,175	6	8
9	32	Interest		31,532,610	275	109,551		3,677,175	12,775	9
10	33	Real Estate Taxes		31,532,610	275	892		3,677,175	104	10
11	26	Insurance		31,532,610	275	191,850		3,677,175	22,373	11
12	27	Advertising & Promotions		31,532,610	275	(485)		3,677,175	(57)	12
13	25	Transportation		31,532,610	275	44,827		3,677,175	5,228	13
14	35	Car Rental		31,532,610	275	435		3,677,175	51	14
15	23	Conferences & Conventions		31,532,610	275	135,279		3,677,175	15,776	15
16	20	Subscriptions, Dues, Awards		31,532,610	275	78,651		3,677,175	9,172	16
17	21	Furniture & Fixtures		31,532,610	275	366		3,677,175	43	17
18	6	Machinery & Equipment		31,532,610	275	0		3,677,175	0	18
19	35	Equipment Rental		31,532,610	275	9,487		3,677,175	1,106	19
20	6	Equipment Repair & Maint		31,532,610	275	96,867		3,677,175	11,296	20
21	20	Employee Recruitment		31,532,610	275	(3,214)		3,677,175	(375)	21
22	7	Security & Waste Removal		31,532,610	275	12,609		3,677,175	1,470	22
23	21	All Other Miscellaneous		31,532,610	275	169,334		3,677,175	19,747	23
24	30	Depreciation		31,532,610	275	395,728		3,677,175	46,148	24
25	TOTALS					$ 5,503,571	$ 2,761,123		$ 641,800	25

Facility Name & ID Number P.A. Peterson Center for Health # 0021238 Report Period Beginning: 07/01/2004 Ending: 6/30/2005

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Lutheran Social Services of Illinois
Street Address: 1001 E. Touhy Ave. Ste 50
City / State / Zip Code: Des Plaines, IL 60018
Phone Number: (847) 635-4600
Fax Number: (847) 635-6764

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	17	Salaries & Wages	Salaries & Benefits	47,695,273	247	$ 849,798	$ 849,798	4,751,681	$ 84,662	1
2	22	Empl Benefits & Taxes		47,695,273	247	202,683		4,751,681	20,192	2
3	19	Prof Fees & Contract		47,695,273	247	148,295		4,751,681	14,774	3
4	21	Supplies, Telephone		47,695,273	247	40,999		4,751,681	4,085	4
5		Postage, Out. Printing		47,695,273	247			4,751,681		5
6	34	Rental of Space		47,695,273	247	2,965		4,751,681	295	6
7	5	Utilities		47,695,273	247	(1)		4,751,681		7
8	6	Bldg Repairs & Maintenance		47,695,273	247			4,751,681		8
9	32	Interest		47,695,273	247			4,751,681		9
10	33	Real Estate Taxes		47,695,273	247			4,751,681		10
11	26	Insurance		47,695,273	247	5,025		4,751,681	501	11
12	27	Advertising & Promotions		47,695,273	247			4,751,681		12
13	25	Transportation		47,695,273	247	13,446		4,751,681	1,340	13
14	35	Car Rental		47,695,273	247	1,039		4,751,681	104	14
15	23	Conferences & Conventions		47,695,273	247	4,132		4,751,681	412	15
16	20	Subscriptions, Dues, Awards		47,695,273	247	4,126		4,751,681	411	16
17	21	Furniture & Fixtures		47,695,273	247			4,751,681		17
18	6	Machinery & Equipment		47,695,273	247			4,751,681		18
19	35	Equipment Rental		47,695,273	247	9,120		4,751,681	909	19
20	6	Equipment Repair & Maint		47,695,273	247			4,751,681		20
21	20	Employee Recruitment		47,695,273	247	45,807		4,751,681	4,564	21
22	7	Security & Waste Removal		47,695,273	247			4,751,681		22
23	21	All Other Miscellaneous		47,695,273	247	1,061		4,751,681	106	23
24	30	Depreciation		47,695,273	247	6,617		4,751,681	659	24
25	TOTALS					$ 1,335,112	$ 849,798		$ 133,014	25

Facility Name & ID Number P.A. Peterson Center for Health # 0021238 Report Period Beginning: 07/01/2004 Ending: 6/30/2005

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Lutheran Social Services of Illinois
Street Address: 1001 E. Touhy Ave. Ste 50
City / State / Zip Code: Des Plaines, IL 60018
Phone Number: (847) 635-4600
Fax Number: (847) 635-6764

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	17	Salaries & Wages	Non Capital Direct Costs	7,037,468	2	$ 131,685	$ 131,685	3,677,175	$ 68,807	1
2	22	Empl Benefits & Taxes		7,037,468	2	61,260		3,677,175	32,009	2
3	19	Prof Fees & Contract		7,037,468	2	20,180		3,677,175	10,544	3
4	21	Supplies, Telephone		7,037,468	2	9,296		3,677,175	4,857	4
5		Postage, Out. Printing		7,037,468	2			3,677,175		5
6	34	Rental of Space		7,037,468	2			3,677,175		6
7	5	Utilities		7,037,468	2			3,677,175		7
8	6	Bldg Repairs & Maintenance		7,037,468	2			3,677,175		8
9	32	Interest		7,037,468	2			3,677,175		9
10	33	Real Estate Taxes		7,037,468	2			3,677,175		10
11	26	Insurance		7,037,468	2	843		3,677,175	440	11
12	27	Advertising & Promotions		7,037,468	2	287		3,677,175	150	12
13	25	Transportation		7,037,468	2	2,802		3,677,175	1,464	13
14	35	Car Rental		7,037,468	2			3,677,175		14
15	23	Conferences & Conventions		7,037,468	2	996		3,677,175	520	15
16	20	Subscriptions, Dues, Awards		7,037,468	2	5,755		3,677,175	3,007	16
17	21	Furniture & Fixtures		7,037,468	2			3,677,175		17
18	6	Machinery & Equipment		7,037,468	2			3,677,175		18
19	35	Equipment Rental		7,037,468	2	822		3,677,175	430	19
20	6	Equipment Repair & Maint		7,037,468	2			3,677,175		20
21	20	Employee Recruitment		7,037,468	2			3,677,175		21
22	7	Security & Waste Removal		7,037,468	2			3,677,175		22
23	21	All Other Miscellaneous		7,037,468	2	(2,561)		3,677,175	(1,338)	23
24	30	Depreciation		7,037,468	2	652		3,677,175	341	24
25	TOTALS					$ 232,017	$ 131,685		$ 121,231	25

Facility Name & ID Number P.A. Peterson Center for Health # 0021238 Report Period Beginning: 07/01/2004 Ending: 06/30/2005

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	Tax Exempt Bonds		X		N/A	9/23/93	$ 1,991,385	$ 3,368,805	8/15/20	0.0738	$ 248,698	1
2												2
3												3
4												4
5												5
	Working Capital											
6	Mgmt Allocation per Sch VIII		X		N/A	N/A	N/A	N/A	N/A	N/A	12,775	6
7												7
8												8
9	TOTAL Facility Related						$ 1,991,385	$ 3,368,805			$ 261,473	9
	B. Non-Facility Related*											
10	N/A				N/A	N/A	N/A	N/A	N/A	N/A		10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 1,991,385	$ 3,368,805			$ 261,473	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. **$** N/A **Line #** N/A

*** Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)**

**** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)**

Facility Name & ID Number P.A. Peterson Center for Health # 0021238 **Report Period Beginning:** 07/01/2004 **Ending:** 06/30/2005

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2004 report.	$ 132,776	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$ 135,145	2
3. Under or (over) accrual (line 2 minus line 1).	$ 2,369	3
4. Real Estate Tax accrual used for 2005 report. (Detail and explain your calculation of this accrual on the lines below.)	$ 141,569	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)**	$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$ 143,938	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
2000	126,110	8
2001	126,586	9
2002	128,164	10
2003	130,278	11
2004	138,118	12

Line 2: Payment of $135,145 is based on 2nd half of 2003 for $ 65,407
Line 2: first half of 2004 for $ 69,738.
Line 4: Accrual of $141,569 is based on, 2nd half of 2004 for $68,380 and first half of 2005 for $ 75,558.

FOR OHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2004	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2004 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2004 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2004.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2004 real estate tax bill to the Department of Public Aid, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2005 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

2004 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME P.A. Peterson Center for Health COUNTY Winnebago

FACILITY IDPH LICENSE NUMBER 0021238

CONTACT PERSON REGARDING THIS REPORT Sonia Channa

TELEPHONE 847 390-1411 FAX #: 847 635-6764

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2004 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2004.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	163B-600 12-19-101-001	3 Stories, Steel Grids, Masonry	$ 139,476.52	$ 139,476.52
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 139,476.52	$ 139,476.52

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the original 2004 tax bills which were listed in Section A to this statement. Be sure to use the 2004 tax bill which is normally paid during 2005.

Facility Name & ID Number P.A. Peterson Center for Health # 0021238 Report Period Beginning: 07/01/2004 Ending: 06/30/2005

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 110,000 B. General Construction Type: Exterior Masonry Frame Steel Grids Number of Stories 3

C. Does the Operating Entity? [X] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [X] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred:
2. Number of Years Over Which it is Being Amortized:
3. Current Period Amortization:
4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Nursing Home	192,020	1985	$ 8,455	1
2					2
3	TOTALS	192,020		$ 8,455	3

Facility Name & ID Number P.A. Peterson Center for Health # 0021238 Report Period Beginning: 07/01/2004 Ending: 06/30/2005

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	174		1942	1942	$ 95,858	$	50	$	$	$ 95,858	4
5			1979	1979	5,596,922	139,923	40	139,923		3,637,416	5
6											6
7											7
8											8
	Improvement Type**										
9	Boiler			1969	5,300		20			5,300	9
10	1975 Addition			1975	9,226		20			9,226	10
11	Remodeling			1977	10,074		16			10,074	11
12	Addition to Bldg			1980	2,874	72	40	72		1,832	12
13	Grab Bars			1982	6,151		10			6,151	13
14	Automatic Door Controls			1983	10,386		10			10,386	14
15	Remodel Suites to singles			1983	20,550		10			20,550	15
16	Convert Suites to Rooms			1984	11,900		10			11,900	16
17	Remodel Suites to singles			1986	15,800		10			15,800	17
18	Repair Damaged Roof			1993	4,296		10			4,296	18
19	Second Floor Redecoration			1994	89,701		10			89,701	19
20	Adjustment per IDPA 2nd Flr Decorating			1994	(2,730)		10			(2,730)	20
21	Landscaping			1980	69,073		10			69,073	21
22	Landscaping - Final 1980			1981	7,309		10			7,309	22
23	Sprinkler System			1984	3,654		10			3,654	23
24	Paving			1985	4,850		10			4,850	24
25	Deluxe Tub with Lift			1986	5,840		10			5,840	25
26	2nd Floor Shower Room			1988	13,898		10			13,898	26
27	Improvements			1988	4,414		10			4,414	27
28	Improvements			1989	15,688		10			15,688	28
29	ADJUSTMENT PER IDPA- 1989 IMPROVEMENTS			1989	20,266		10			20,266	29
30	ADJUSTMENT PER IDPA- 1989 IMPROVEMENTS			1989	35,052		10			35,052	30
31	New Roof			1990	41,995	1,680	25	1,680		26,022	31
32	Public Address System			1990	4,200		5			4,200	32
33	First Floor Remodeling			1990	62,210	2,488	25	2,488		36,114	33
34	ADJUSTMENT PER IDPA- 1990 1rst Flr Remodeling			1990	(3,590)		25	(144)	(144)	(2,226)	34
35	Parker Bath Tub			1991	9,390		7			9,390	35
36	Third Floor Remodeling			1992	99,312		10			99,312	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number P.A. Peterson Center for Health # 0021238 Report Period Beginning: 07/01/2004 Ending: 06/30/2005

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	ADJUSTMENT PER IDPA 1992 3rd Flr Remodeling	1992	$ (78,784)	$	10	$	$	$ (78,784)	37
38	ADJUSTMENT PER IDPA 1992 3rd Flr Remodeling	1991	54,938		10			54,938	38
39	Underground Fual Tank	1993	10,523		5			10,523	39
40	Security Cameras	1993	3,496		5			3,496	40
41	Bath Tub	1995	3,766	377	10	377		3,625	41
42	Parking lot	1995	16,425	657	25	657		6,248	42
43	IDPH Remodeling	1995	162,992	16,299	10	16,299		155,419	43
44	New Subacute Unit	1995	677,548	27,102	25	27,102		257,750	44
45	ADJUSTMENT PER IDPA 1995 Improvement to Equipment	1995	(63,067)		25	(2,523)	(2,523)	(26,491)	45
46	Adjustment per IDPA - 1995 Improv to CORF	1995	(30,219)		25	(1,208)	(1,208)	(12,687)	46
47	Parking Lot # 94-502	1995	416	42	10	42		396	47
48	Carpet/Vinyl Dining Room	1995	12,220	1,222	10	1,222		11,652	48
49	Glass & Glazing for Door	1997	775	78	10	78		636	49
50	New Doors & Smoke Closet	1997	1,910	191	10	191		1,524	50
51	Floor Covering in Kitchen	1998	2,047	205	10	205		1,497	51
52	Repair Roof-P.A.P.	1998	53,433	2,137	25	2,137		14,950	52
53	Zoning Permit Parking Lot	1998	898	90	10	90		619	53
54	Planting & Mulch for P.A.	1998	7,186	719	10	719		4,955	54
55	Parking Lot Expansion	1998	778	78	10	78		536	55
56	North Parking Lot Remodeling	1998	80,391	8,039	10	8,039		55,430	56
57	Consulting N. Parking Lot	1998	806	81	10	81		549	57
58	Repair Conduit Damage	1998	3,982	398	10	398		2,613	58
59	Carpeting for Apartment C	1999	17,200	1,720	10	1,720		13,759	59
60	Office Partition PAP	1999	4,862	486	10	486		2,252	60
61	Corridor Ventilation Upgrade	2000	63,500	2,540	25	2,540		12,891	61
62	Plumbing	2001	2,963	296	10	296		1,477	62
63	Install Cumberland Print	2001	3,160	126	25	126		631	63
64	Windows	2001	10,000	400	25	400		1,997	64
65	Porch- Railings-Floors	2001	7,648	306	25	306		1,527	65
66	Roofing	2001	11,475	1,148	10	1,148		5,719	66
67	Porch- Railings-Floors	2001	13,612	544	25	544		2,719	67
68	Fan Coil Unit	2001	5,635	564	10	564		2,808	68
69	Contract Flooring-Interior	2001	2,920	117	25	117		563	69
70	TOTAL (lines 4 thru 69)		$ 7,335,304	$ 210,125		$ 206,250	$ (3,875)	$ 4,784,353	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number P.A. Peterson Center for Health # 0021238 Report Period Beginning: 07/01/2004 Ending: 06/30/2005

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 7,335,304	$ 210,125		$ 206,250	$ (3,875)	$ 4,784,353	1
2	Wall coverings	2001	2,990	120	25	120		577	2
3	Furniture	2001	36,175	1,447	25	1,447		6,979	3
4	Carpet-Furnish and instal	2001	1,095	44	25	44		211	4
5	Room Equipment Furniture	2001	4,372	175	25	175		829	5
6	Room Equipment Furniture	2001	687	27	25	27		130	6
7	Room Equipment Furniture	2001	1,245	50	25	50		236	7
8	Room Equipment Furniture	2001	840	34	25	34		159	8
9	Room Equipment Furniture	2001	1,123	45	25	45		213	9
10	Room Equipment Furniture	2001	5,878	235	25	235		1,115	10
11	Room Equipment Furniture	2001	550	22	25	22		102	11
12	Room Equipment Furniture	2001	2,534	101	25	101		464	12
13	Carpet Wallpaper	2001	12,410	1,241	10	1,241		5,560	13
14	Furnish and Install Carpet	2001	840	84	10	84		369	14
15	Electric work 3rd Flr Kitchen	2001	3,348	134	25	134		590	15
16	Renovation of Assisted Living	2001	880	35	25	35		143	16
17	Renovation of Assisted Living	2001	4,363	436	10	436		1,775	17
18	Renovation of Assisted Living	2001	2,129	85	25	85		340	18
19	Soft Start for Elevator	2001	7,466	747	10	747		2,976	19
20	Architectual Services	2001	2,958	118	25	118		472	20
21	HVAC System Revisions	2001	9,000	900	10	900		3,587	21
22	Rewire rooms 206 & 208	2001	975	39	25	39		152	22
23	Architectual Services	2001	2,338	94	25	94		365	23
24	Landscaping	2001	8,954	895	10	895		4,117	24
25	Furnish and Install Carpet	2002	1,068	107	10	107		408	25
26	Deposit To Start Kitchen	2002	3,531	353	10	353		1,347	26
27	Floor Improvements	2002	1,150	115	10	115		420	27
28	Improvements	2002	19,528	1,953	10	1,953		7,126	28
29	Instalation of New Fire Place	2002	3,381	338	10	338		1,234	29
30	Architectual Services	2002	876	88	10	88		320	30
31	First Floor Construction	2002	35,000	3,500	10	3,500		12,187	31
32	Architectual Services	2002	1,962	196	10	196		683	32
33	Improvements	2002	2,500	100	25	100		349	33
34	TOTAL (lines 1 thru 33)		$ 7,517,450	$ 223,983		$ 220,108	$ (3,875)	$ 4,839,888	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number P.A. Peterson Center for Health # 0021238 Report Period Beginning: 07/01/2004 Ending: 06/30/2005

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 7,517,450	$ 223,983		$ 220,108	$ (3,875)	$ 4,839,888	1
2	Improvements	2002	1,870	187	10	187		635	2
3	Instalation of New Fire place	2002	1,187	119	10	119		403	3
4	Labor cost for removing	2002	6,690	669	10	669		2,221	4
5	Architectural Time	2002	443	44	10	44		143	5
6	Redecorate Ground Floor	2003	82,495	8,250	10	8,250		17,547	6
7	Duct work for air conditioning	2003	1,059	212	5	212		450	7
8	Redecorate Ground Floor	2003	5,535	553	10	553		1,130	8
9	Redecorate Ground Floor	2003	2,692	269	10	269		550	9
10	Redecorate Ground Floor	2003	2,700	270	10	270		551	10
11	Redecorate Ground Floor	2003	5,655	566	10	566		1,155	11
12	Redecorate Ground Floor	2003	1,584	158	10	158		323	12
13	Redecorate Ground Floor	2003	11,887	1,189	10	1,189		2,428	13
14	Redecorate Ground Floor	2003	1,098	110	10	110		224	14
15	Redecorate Ground Floor	2003	880	88	10	88		180	15
16	Redecorate Ground Floor	2003	468	47	10	47		95	16
17	Redecorate Ground Floor	2003	4,278	856	5	856		1,747	17
18	Redecorate Ground Floor	2003	17,076	3,415	5	3,415		6,972	18
19	Redecorate Ground Floor	2003	29,523	2,952	10	2,952		6,029	19
20									20
21	Emergency Plumbing	2004	5,048	505	10	505		525	21
22	Emergency Plumbing	2004	465	47	10	47		48	22
23	Emergency Outlets	2004	4,575	183	25	183		190	23
24									24
25	Piston Repair for Elevator	2005	8,061	322	25	322		282	25
26	Emergency Plumbing	2005	285	1	10	1		1	26
27	Final Ground Floor Renovations	2005	4,507	19	10	19		19	27
28	Piston Replacement for Elevator	2005	1,064	19	25	19		19	28
29	Piston Replacement for Elevator	2005	24,182	440	25	440		440	29
30	Shelter care upgrade	2005	10,959	128	25	128		128	30
31	Shelter care upgrade	2005	2,423	28	25	28		28	31
32	Fire Damper Project	2005	115,128	189	25	189		189	32
33	Instalation of Fire dampers	2005	63,740	105	25	105		105	33
34	TOTAL (lines 1 thru 33)		$ 7,935,007	$ 245,923		$ 242,048	$ (3,875)	$ 4,884,645	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number P.A. Peterson Center for Health # 0021238 Report Period Beginning: 07/01/2004 Ending: 06/30/2005

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		$ 7,935,007	$ 245,923		$ 242,048	$ (3,875)	$ 4,884,645	1
2	Fitness Center & Computer Room		73,833	121	25	121		121	2
3	Shelter Care Upgrade		76,077	383	25	383		383	3
4	Shelter Care Upgrade		82,560	136	25	136		136	4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15	Management Assets- Security System	1999	60,008		10	224	224	N/A	15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 8,227,485	$ 246,563		$ 242,912	$ (3,651)	$ 4,885,285	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number P.A. Peterson Center for Health # 0021238 Report Period Beginning: 07/01/2004 Ending: 06/30/2005

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 1,811,200	$ 156,954	$ 200,382	$ 43,428	Various	$ 562,350	71
72	Current Year Purchases	239,168	8,702	12,153	3,451	Various	12,153	72
73	Fully Depreciated Assets	741,510					741,510	73
74								74
75	TOTALS	$ 2,791,878	$ 165,656	$ 212,535	$ 46,879		$ 1,316,013	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Resident Transp.	Handicapped Bus 1991	1991	$ 38,800	$	$	$	7	$ 38,800	76
77										77
78										78
79										79
80	TOTALS			$ 38,800	$	$	$		$ 38,800	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 11,066,618	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 412,219	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 455,447	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 43,228	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 6,240,098	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	95 Improvement CORF 1995	$ 30,219	$ 1,208	$ 13,895	86
87	Dodge Van 1997	17,032		17,032	87
88					88
89	Management Autos	2,495	45	N/A	89
90					90
91	TOTALS	$ 49,746	$ 1,253	$ 30,927	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number P.A. Peterson Center for Health # 0021238 Report Period Beginning: 07/01/2004 Ending: 06/30/2005

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
   If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34. N/A
   This amount was calculated by dividing the total amount to be amortized by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
    Beginning
    Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2006	$
13.	/2007	$
14.	/2008	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO
16. Rental Amount for movable equipment: $ 23,642 Description: See Attached Schedule
    (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number P.A. Peterson Center for Health # 0021238 Report Period Beginning: 07/01/2004 Ending: 06/30/2005

XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? [ ] YES [X] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER CNA ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER CNA ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)	N / A			
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training CNAs from other facilities.

$

D. NUMBER OF CNAs TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.
(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	$		$	$		$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts		N / A					9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			$		$	$		$	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number P.A. Peterson Center for Health # 0021238 **Report Period Beginning:** 07/01/2004 **Ending:** 06/30/2005

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 06/30/2005 **(last day of reporting year)**

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	N / A		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost			16
17	Accumulated Depreciation (book methods)			17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable			30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$	$	48

***(See instructions.)**

Facility Name & ID Number P.A. Peterson Center for Health # 0021238 Report Period Beginning: 07/01/2004 Ending: 06/30/2005

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ N / A	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)		7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$	24 *

Note:
Lutheran Social Services of Illinois is unable to provide meaninful comparative balance sheets or statements of changes in equity for individual programs due to the commingling of cash, other asset and most liabilities in a complex, multi-funtional service agency.

Any Balance Sheet prepared with only those Assets with specific programs would not balance or present meaningful picture of that programs's Financial Statu

*** This must agree with page 17, line 47.**

Facility Name & ID Number P.A. Peterson Center for Health # 0021238 Report Period Beginning: 07/01/2004 Ending: 06/30/2005

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 9,369,271	1
2	Discounts and Allowances for all Levels	(502,693)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 8,866,578	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	2,494	13
14	Non-Patient Meals	7,180	14
15	Telephone, Television and Radio	23,857	15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray	738	20
21	Other Medical Services		21
22	Laundry	17,113	22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 51,382	23
	D. Non-Operating Revenue		
24	Contributions	3,221	24
25	Interest and Other Investment Income***		25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 3,221	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 8,921,181	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,525,836	31
32	Health Care	4,957,821	32
33	General Administration	2,582,404	33
	B. Capital Expense		
34	Ownership	825,134	34
	C. Ancillary Expense		
35	Special Cost Centers	73,295	35
36	Provider Participation Fee		36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 9,964,490	40
41	**Income before Income Taxes (line 30 minus line 40)****	(1,043,309)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (1,043,309)	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return?** N/A **If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

**** **Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number P.A. Peterson Center for Health # 0021238 Report Period Beginning: 07/01/2004 Ending: 06/30/2005

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,998	3,395	$ 91,373	$ 26.91	1
2	Assistant Director of Nursing	10,786	12,415	182,244	14.68	2
3	Registered Nurses	34,363	38,302	858,318	22.41	3
4	Licensed Practical Nurses	29,419	32,359	577,369	17.84	4
5	CNAs & Orderlies	84,012	90,681	944,267	10.41	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	5,310	6,108	121,783	19.94	9
10	Activity Assistants					10
11	Social Service Workers	3,335	3,951	53,735	13.60	11
12	Dietician					12
13	Food Service Supervisor	7,496	8,388	119,316	14.22	13
14	Head Cook	6,707	7,198	65,827	9.15	14
15	Cook Helpers/Assistants	21,492	23,279	179,075	7.69	15
16	Dishwashers					16
17	Maintenance Workers	5,184	6,007	103,436	17.22	17
18	Housekeepers	17,202	19,024	143,431	7.54	18
19	Laundry					19
20	Administrator					20
21	Assistant Administrator	1,053	1,228	46,073	37.52	21
22	Other Administrative	1,744	1,971	36,563	18.55	22
23	Office Manager					23
24	Clerical	7,531	8,431	82,590	9.80	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	8,524	9,630	97,533	10.13	31
32	Other Health Care(specify)					32
33	Other(specify)	2,175	2,424	51,644	21.31	33
34	TOTAL (lines 1 - 33)	249,331	274,791	$ 3,754,577 *	$ 13.66	34

* This total must agree with page 4, column 1, line 45. ** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	As Needed	$ 28,776	1,3	35
36	Medical Director	As Needed	24,136	9,3	36
37	Medical Records Consultant	As Needed	3,425	10,3	37
38	Nurse Consultant	As Needed	170	10,3	38
39	Pharmacist Consultant	As Needed	1,394	10,3	39
40	Physical Therapy Consultant	As Needed	969,609	10a,3	40
41	Occupational Therapy Consultant	As Needed	489,553	10a,3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	As Needed	39,349	10a,3	43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify) Medical & Pysch. Ser	As Needed	203,489	Various	46
47	Legal & Audit Accounting	As Needed	115,894	19,3	47
48					48
49	TOTAL (lines 35 - 48)		$ 1,875,795		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)		$		53

Facility Name & ID Number P.A. Peterson Center for Health # 0021238 Report Period Beginning: 07/01/2004 Ending: 06/30/2005

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Peggy J. Holt	Administrator	0	$ 46,073
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 46,073

B. Administrative - Other

Description	Amount
	$
TOTAL (agree to Schedule V, line 17, col. 3)	$
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Duane, Morris & Heckscher	Legal Fees	$ 15,761
Frost Ruttenberg and Roth	Audit & Accounting Fees	29,187
Authority Health Care Consulting	Professional Fees & Contract	2,017
The Tintari Group Inc.	Professional Fees & Contract	36,579
Fred Benjamin	Professional Fees & Contract	32,500
Sarah J. Triezenberg	Professional Fees & Contract	248
LSSI	Management Services	878,208
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 994,500

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 213,022
Unemployment Compensation Insurance	14,327
FICA Taxes	270,722
Employee Health Insurance	306,114
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Pension	192,859
Management Allocation Benefits	110,256
TOTAL (agree to Schedule V, line 22, col.8)	$ 1,107,300

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
N/A		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	2,754
Health Care Worker Background Check	
(Indicate # of checks performed)	
Advertising & Promation, Awards, Grants	37,142
Subscriptions and Books	847
Membership Dues	5,960
Licenses & Fees	
Management Allocation	16,779
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 63,482

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Vehicle Operating Cost	5,806
Employee Milage Payments	4,517
Meals, Lodging	2,252
Seminar Expense	1,217
Conference & Conventions	2,000
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 15,792

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number P.A. Peterson Center for Health # 0021238 Report Period Beginning: 07/01/2004 Ending: 06/30/2005

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009	FY2010
1	N / A		$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number P.A. Peterson Center for Health # 0021238 **Report Period Beginning:** 07/01/2004 **Ending:** 06/30/2005

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **Life Services Network $5960**

(3) Did the nursing home make political contributions or payments to a political action organization? **No** If YES, have these costs been properly adjusted out of the cost report?

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **7 years**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **22,405** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **73,295**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **Yes** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **0** Has any meal income been offset against related costs? **Yes** Indicate the amount. $ **7,000**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? **0%**
d. Have vehicle usage logs been maintained? **Yes**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **Yes**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **Yes**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ N/A

(17) Has an audit been performed by an independent certified public accounting firm? **Yes**
Firm Name: **Clifton Gunderson LLP** The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? **No** If no, please explain. **In Progress, will send as soon as availa**

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **N/A**
Attach invoices and a summary of services for all architect and appraisal fees.